SERFF Tracking Number:	*ZURC-125756620*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*39810*
Company Tracking Number:	*CW-AH-27574*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing*		
Project Name/Number:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing/CW-AH-27574*		

Filing at a Glance

Company: Zurich American Insurance Company

Product Name: CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing	SERFF Tr Num: ZURC-125756620	State: ArkansasLH
TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 39810
Sub-TOI: H21.000 Health - Other	Co Tr Num: CW-AH-27574	State Status: Approved-Closed
Filing Type: Form	Co Status: Not Applicable	Reviewer(s): Rosalind Minor
	Author: Linda Kulpa	Disposition Date: 08/16/2008
	Date Submitted: 07/31/2008	Disposition Status: Approved-Closed
Implementation Date Requested: 09/01/2008		Implementation Date:

State Filing Description:

General Information

Project Name: CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing	Status of Filing in Domicile: Authorized
Project Number: CW-AH-27574	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Blanket
Filing Status Changed: 08/16/2008	
State Status Changed: 08/16/2008	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

This is a new Integrated Stop Loss Policy form filing responding to the needs of fully-insured groups moving to a self-funded environment. This Policy is intended to provide insurance for self-funded group health plans against catastrophic losses for the self-funded group health plan as a whole.

This Policy will be marketed through brokers, agents, and sales employees. The Company's Integrated Stop Loss

SERFF Tracking Number:	*ZURC-125756620*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*39810*
Company Tracking Number:	*CW-AH-27574*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing*		
Project Name/Number:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing/CW-AH-27574*		

Policies will be underwritten by the Company's managing general underwriter, Spectrum Underwriting Managers, Inc.

Company and Contact

Filing Contact Information

Linda Kulpa, Filing Analyst
1400 American Lane
Schaumburg, IL 60196

linda.kulpa@zurichna.com
(847) 605-3763 [Phone]
(847) 605-7768[FAX]

Filing Company Information

Zurich American Insurance Company
1400 American Lane
Schaumburg, IL 60102
(847) 605-6000 ext. [Phone]

CoCode: 16535
Group Code: 212
Group Name:
FEIN Number: 36-4233459

State of Domicile: New York
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	Form Filing fee
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Zurich American Insurance Company	$50.00	07/31/2008	21717570

SERFF Tracking Number:	*ZURC-125756620*	*State:*	*Arkansas*
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Project Name/Number:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing/CW-AH-27574*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/16/2008	08/16/2008

SERFF Tracking Number:	*ZURC-125756620*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*39810*
Company Tracking Number:	*CW-AH-27574*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing*		
Project Name/Number:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing/CW-AH-27574*		

Disposition

Disposition Date: 08/16/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ZURC-125756620*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*39810*
Company Tracking Number:	*CW-AH-27574*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing*		
Project Name/Number:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing/CW-AH-27574*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Statement of Variables	Approved-Closed	Yes
Supporting Document	Readability	Approved-Closed	Yes
Supporting Document	Explanatory Memo	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Integrated Stop Loss Policy	Approved-Closed	Yes
Form	Policyholder Disclosure Statement	Approved-Closed	Yes
Form	Aggregate Terminal Liability Endorsement	Approved-Closed	Yes
Form	Retiree Endorsement	Approved-Closed	Yes
Form	Organ and Tissue Transplant Coverage Endorsement	Approved-Closed	Yes
Form	Blank Endorsement	Approved-Closed	Yes
Form	Privacy Notice	Approved-Closed	Yes

SERFF Tracking Number:	*ZURC-125756620*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*39810*
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Project Name/Number:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing/CW-AH-27574*		

Form Schedule

Lead Form Number: U-ISL-100-A CW (06/08)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	U-ISL-100-A CW (06/08)	Policy/Contract/Fraternal Certificate	Integrated Stop Loss Policy	Initial		39	U-ISL-100-A CW - ZAIC Integrated Stop Loss Policy.pdf
Approved-Closed	U-ISL-101-A CW (06/08)	Other	Policyholder Disclosure Statement	Initial		41	U-ISL-101-A CW - ZAIC Policyholder Disclosure Statement.pdf
Approved-Closed	U-ISL-102-A CW (06/08)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Aggregate Terminal Liability Endorsement	Initial		40	U-ISL-102-A CW - ZAIC Aggregate Terminal Liability Endorsement.pdf
Approved-Closed	U-ISL-103-A CW (06/08)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Retiree Endorsement	Initial		57	U-ISL-103-A CW - ZAIC Retiree Endorsement.pdf
Approved-Closed	U-ISL-104-A CW (06/08)	Policy/Contract/Fraternal Certificate:	Organ and Tissue Transplant Coverage Endorsement	Initial		59	U-ISL-104-A CW - ZAIC Organ and Tissue

		Amendment, Insert Page, Endorsement or Rider				Transplant Coverage Endorsement.pdf
Approved-Closed	U-ISL-105-A CW (06/08)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Blank Endorsement	Initial	57	U-ISL-105-A CW - ZAIC Blank Endorsement.pdf
Approved-Closed	U-ISL-106-A CW (06/08)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Privacy Notice	Initial	23	U-ISL-106-A CW - ZAIC Privacy Notice.pdf

Integrated Stop Loss Policy

Zurich American Insurance Company
Schaumburg, Illinois

This **Policy** is issued to

Policyholder: [ABC Company including the following companies]
Policy Number: [123456]
Effective Date: From: [January 1, 2001] To: [December 31, 2001]
12:01 A.M. Standard Time at the Address indicated in SECTION I

The **Company** agrees to reimburse the **Policyholder** for certain **Plan Benefits** the **Policyholder** has provided under a self-funded benefit plan (**Plan**). Such reimbursement will be subject to all the terms and conditions of this **Policy**.

This **Policy** is issued in consideration of:
(1) the application made by the **Policyholder**; and
(2) the payment of the initial premium on the Effective Date of this **Policy**; and
(3) the payment of all subsequent premiums when due; and
(4) the continual compliance by the **Policyholder** with all the terms and conditions of this **Policy**.

This **Policy** is governed by the laws of the State of [_____]

The **Policyholder** may cancel this coverage within [ten (10)] days after receipt of the Master **Policy** by returning it to the **Company** or the Agent. If it is returned for cancellation, the **Company** will refund any premiums paid. This coverage will be void.

In Witness Whereof, the **Company** caused this **Policy** to be executed and attested, and if required by state law, this **Policy** shall not be valid unless countersigned by its authorized representative.

The provisions on the following pages are a part of this **Policy.**

Licensed Resident Agent _____
(if required by law in this state)

Thomas A. Bradley
President
Zurich American Insurance Company

David A. Bowers
Corporate Secretary
Zurich American Insurance Company

This **Policy** is Non-Participating

TABLE OF CONTENTS

SECTION I

[RENEWAL] APPLICATION FOR INTEGRATED STOP LOSS INSURANCE COVERAGE

Applicant (**Policyholder**): _____ Proposed Effective Date: _____

Address: _____ Initial Premium Deposit: $_____

City, State, Zip Code: _____ Telephone Number: (____) _____

Coverage Applied For:

SECTION II

SCHEDULE OF INTEGRATED STOP LOSS INSURANCE

Enrollment (**Covered Units**) at Effective Date: [Employees] [Single____] [Family_____]
Policy Period from [January 1, 2001] through [December 31, 2001]
Minimum number of lives and/or participation: [ ]

AGGREGATE STOP LOSS

Claims Basis:
- ☐ **Incurred** and **Paid** [12/12]
- ☐ Run-In [15/12]
- ☐ Run-Out [12/15]
- ☐ **Paid**
- ☐ [Other _____]

Benefit Period: Eligible **Plan Benefits Incurred** from [January 1, 2001] through [December 31, 2001] and **Paid** from [January 1, 2001] through [December 31, 2001]

Aggregate Terminal Liability: ☐ Yes ☐ No

[It is hereby agreed and understood that the Aggregate Stop Loss Coverage selected does not provide reimbursement to the **Policyholder** for any **Plan Benefits Incurred** prior to the beginning of the **Benefit Period** or, for any **Plan Benefits Paid** after the **Benefit Period** has ended. Only **Plan Benefits** that are both **Incurred** and **Paid** by the **Policyholder** within the [twelve (12)] month **Policy Period** are reimbursable under the Aggregate Stop Loss Coverage selected.]

[It is hereby agreed and understood that the Aggregate Stop Loss Coverage selected does not provide reimbursement to the **Policyholder** for any **Plan Benefits** which are not **Paid** within the current **Benefit Period**. Only **Plan Benefits** that are both **Incurred** and **Paid** by the **Policyholder** within the **Benefit Period** are reimbursable under the Aggregate Stop Loss Coverage selected.]

Aggregate **Percentage Reimbursable**: [100%]
[**Plan Benefits** for treatment rendered at the **Policyholder's** facilities (Domestic **Plan Benefits**): [80%]
Plan Benefits for treatment rendered at outside facilities (Foreign **Plan Benefits**): [100%]]

Monthly Aggregate **Deductible** Factors: [$275.00 Employee/Composite] [$150.00 Single] [$350.00 Family]

Minimum **Annual Aggregate Deductible**: [$900,000] based on number of initial **Covered Units** multiplied by the number of months in the **Policy Period** multiplied by [90%] multiplied by the corresponding Monthly Aggregate **Deductible** Factors

Annual Aggregate Deductible for any one **Policy Period** means the greater of:
(1) The cumulative monthly total of **Covered Units** multiplied by the Monthly Aggregate **Deductible** Factors; or
(2) The Minimum **Annual Aggregate Deductible**

Lifetime Limit of Liability per **Covered Person**: [$1,000,000]
[Limit of Liability for the **Policy Period**: [$5,000,000]]
[**Plan Benefits Incurred** prior to the **Policy Period** will be limited to $_____]

PREMIUMS

Aggregate: [Monthly] [$2.75 Employee] [$5,000 Annual]
[Minimum Annual Premium:] [$50,000]
[Aggregate Terminal Liability:] [$1.00 Employee]

PLAN BENEFITS INCLUDED

☐ Medical
☐ Free Standing Drug Program
☐ Dental
☐ Vision
☐ Other _____

ENDORSEMENTS INCLUDED

[Aggregate Terminal Liability] [Other]

Third Party Administrator: _____

If coverage is accepted, this SCHEDULE OF INTEGRATED STOP LOSS INSURANCE will become a part of the **Policy**.

INSURANCE FRAUD WARNING
[**Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading, is guilty of insurance fraud and is subject to criminal and/or civil penalties.**]

The applicant hereby applies for Integrated Stop Loss Insurance Coverage and:

1. Represents that the answers included in this [Renewal] Application for Integrated Stop Loss Insurance Coverage have been reviewed and are true and complete; and
2. Understands and agrees that the insurance applied for shall not become effective until the [Renewal] Application for Integrated Stop Loss Insurance Coverage is approved by the **Company** and the initial premium deposit is received; and
3. Agrees that if the insurance applied for is approved by the **Company**, the applicant will pay all premiums due after the effective date of the insurance, including any premiums which may accumulate between the effective date of the insurance and the date the **Policy** is issued.

This [Renewal] Application for Integrated Stop Loss Insurance Coverage, as it may be amended, will become part of the **Policy**, if issued.

Signed at _____ this _____ day of _____ 20_____

Signed by _____ Title _____

FOR HOME OFFICE USE ONLY

Approved: ☐ Yes ☐ No By: _____ Date: _____

SECTION III

DEFINITIONS

ANNUAL AGGREGATE DEDUCTIBLE as shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE for any one **Policy Period** means the greater of:
1. The cumulative monthly total of **Covered Units** multiplied by the Monthly Aggregate **Deductible** Factors; or
2. The Minimum **Annual Aggregate Deductible**.

BENEFIT PERIOD means the period of time in which **Plan Benefits** must be **Incurred** by the **Covered Person** and **Paid** by the **Plan** to be eligible for reimbursement under this **Policy**. This period does not alter the **Policy** effective date and **Policy Period**, nor does it waive the eligibility requirements of this **Policy**.

COMPANY means the Zurich Company issuing this **Policy**.

COVERED BENEFITS means the benefits provided for **Covered Persons** by the **Plan** as defined in the **Policy**. [Benefits for occupational accidents and illness and fees for administration purposes are not **Covered Benefits**.]

COVERED PERSON means any eligible individual entitled to benefits under the **Policyholder's Plan**.

COVERED UNIT(S) for the purposes of determining the premiums payable or the **Annual Aggregate Deductible** means the following:
1. Employee; or
2. Employee with dependents; or
3. Such other defined unit as agreed between the **Company** and the **Policyholder**.

DEDUCTIBLE(S) means the Aggregate **Deductible(s)** as shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE.

ELIGIBLE CLAIM EXPENSE(S) means **Plan Benefits** which are **Incurred** by a **Covered Person** under the **Plan(s)** and for which benefits have been **Paid** by the **Policyholder** in accordance with the terms of the **Plan(s)** on the Claims Basis shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE. **Eligible Claim Expenses** which are covered under the terms of the **Plan(s)**, **Paid** by the **Policyholder** and not excluded under the terms of this **Policy** can be used either to satisfy the **Deductible(s)** of this **Policy** or included in the calculation of the reimbursements payable under this **Policy**.

EXPERIMENTAL OR INVESTIGATIONAL TREATMENT means a treatment, procedure, service, device, or drug (treatment) which will be considered to be experimental or investigational if:
1. The treatment has not been approved by the United States Food and Drug Administration (FDA) at the time the treatment is provided; or
2. The treatment is identified as a Phase I, II, III, or IV clinical trial or under study to determine its maximum tolerated dose, its safety, its efficacy, or its toxicity as compared with the standard means of treatment or diagnosis; or
3. The treatment is governed by a written protocol that references determinations of safety, toxicity and/or efficacy in comparison to conventional alternatives and/or has been approved or is subject to the approval by an Institutional Review Board (IRB) or the appropriate committee of the provider institution; or
4. The treatment is being provided subject to the **Covered Person's** execution of an informed consent that references determinations of safety, toxicity or efficacy in comparison to conventional alternatives; or
5. The predominant opinion of medical experts as expressed in published peer-reviewed literature is that further research is necessary in order to determine safety, toxicity, or efficacy in comparison to conventional alternatives.

   Experimental or Investigational Treatment will be considered an **Eligible Claim Expense** under this **Policy** when the following criteria are met:
   1. Treatment protocol identified as a Phase II, III, or IV clinical trial, or the equivalent, will be considered an **Eligible Claim Expense** when all of the following criteria are met:
      (a) There is no clearly superior, non-investigational treatment alternative and there is a reasonable expectation that the treatment will be more effective than the non-investigational alternative; and
      (b) The clinical trial is subject to review by an IRB and has been approved by the governing local IRB; and
      (c) The **Covered Person** has executed an informed consent, which has been approved by the IRB; and

(d) The treatment protocol has been approved by one or more of the following organizations, the treatment is being provided within one of the centers designated by the clinical trial sponsor as a participating center and is being provided under the direction of the principal investigator at that center:
   i. National Institutes of Health (NIH).
   ii. NIH cooperative group or center.
   iii. United States Department of Health and Human Services (HHS), which includes the Center for Medicare and Medicaid Services (CMS).
   iv. FDA.
   v. United States Department of Defense.
   vi. United States Department of Veterans Affairs; or

2. Treatment utilizing drugs previously approved by the FDA for non-approved indications when all of the following criteria are met:
   (a) There is no clearly superior, non-investigational treatment alternative and there is a reasonable expectation that the treatment will be more effective than the non-investigational alternative.
   (b) The provider has complied with all of the IRB's requirements for providing the treatment; or
3. Treatment utilizing Investigator sponsored trials which are done in accordance with IRB approved protocols in an academic medical center that is a recipient of NIH grants and which meets all of the criteria in 1.(a) through 1.(d) above. Investigator sponsored trials will be considered on a case-by-case basis. Investigator or drug company sponsored trials in which there is no academic medical center involvement and where the principal investigator is not affiliated with an academic medical center will not be considered for coverage except by recommendation of an independent third party reviewer.

To determine if any treatment meets the standards for coverage, the **Company** reserves the right to obtain an independent third party review.

INCURRED means:
1. with respect to services, the date on which the services are rendered to the **Covered Person**; or
2. with respect to supplies, the date on which the supplies are given to the **Covered Person**[; or
3. with respect to disability income benefits, on the date each periodic benefit payment becomes payable to the **Covered Person**].

LIFETIME LIMIT OF LIABILITY means the amount shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE and is the maximum amount the **Company** will reimburse the **Policyholder** with respect to any **Covered Person(s)** under this **Policy** issued by the **Company** but not more than the Lifetime Maximum specified in the **Plan**.

MEDICALLY NECESSARY AND APPROPRIATE means that a service, supply or drug is provided by a recognized provider, is accepted by the FDA and is generally accepted as the standard of care for the control or cure of the illness or injury being treated by physicians practicing in the same or related specialty field.

PAID means:
1. the draft or check for payment of **Plan Benefits** is issued and released by the **Policyholder** by mail or other means or funds are transmitted electronically by the plan supervisor to the payee; and
2. sufficient funds are available:
   a. in the account from which the draft or check is issued for a non-zero balance account or from the account from which the funds are electronically transmitted; or
   b. to permit the draft or check to be honored in a zero-balance account.

PERCENTAGE REIMBURSABLE means the percentage at which the **Company** will consider **Plan Benefits** under this **Policy**.

PLAN(S) means the **Policyholder's** self-funded benefit plan(s) as described in its **Plan(s)** document as required by either federal or state law. A copy of the **Plan(s)** document is attached to this **Policy** for the purpose of determining the **Company's** liability under this **Policy**.

PLAN BENEFITS means **Eligible Claim Expenses** which are **Incurred** by a **Covered Person** under the **Plan(s)** and for which benefits have been **Paid** by the **Policyholder** in accordance with the terms of the **Plan(s)** on the Claim Basis shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE. **Plan Benefits** which are covered under the terms of the **Plan(s)**, **Paid** by the **Policyholder** and not excluded under the terms of the **Policy** can be used to either satisfy the **Deductible(s)** of the **Policy** or included in the calculation of the reimbursements payable under this **Policy**.

POLICY means this Integrated Stop Loss Policy.

POLICYHOLDER means the applicant named in the [Renewal] Application for Integrated Stop Loss Insurance Coverage.

POLICY PERIOD means the dates shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE.

PROOF OF LOSS means receipt of a complete claim form, satisfactory to the **Company**, and other supporting documentation required by the **Company**.

PROVIDER NETWORK(S) means a network(s) or similar organization consisting of selected health care providers (e.g., physicians and hospitals) that provide services or supplies to a **Covered Person** at a discounted or pre-determined price.

[**REASONABLE AND CUSTOMARY CHARGE** means the normal charge made to an individual without insurance and which does not exceed the general level of fees and prices normally charged for a given procedure or supply within the same geographical area in which the expense was incurred. The **Reasonable and Customary Charge** will be determined by the **Company** based upon the most current version of the reasonable and customary fee schedules [published by [Ingenix] [maintained by the **Policyholder's Third Party Administrator**]. In no event will the allowable charge exceed: 1) the amount charged to an individual without insurance; or 2) the **Provider Network** discounted or pre-determined price; or 3) the [90th] percentile of the most current version of the reasonable and customary fee schedules [published by [Ingenix] [maintained by the **Policyholder's Third Party Administrator**], whichever is less.]

THIRD PARTY ADMINISTRATOR means a firm or person which has been retained by the **Policyholder** to pay claims and/or provide other administrative services on behalf of the **Policyholder**.

WAR means expenses resulting from war or any act of war declared or undeclared, whether civil or international, and any substantial armed conflict between organized government forces of a military nature.

SECTION IV

AGGREGATE STOP LOSS

During the **Policy Period** and while this **Policy** is in force, on a [weekly] basis, the **Company** will advance to and pay to the **Policyholder** as a loan the Aggregate Stop Loss reimbursement, if any, within [four (4)] days after the **Company's** acceptance of the **Proof of Loss** and verification that Eligible **Plan Benefits** have been **Incurred** and **Paid** within the **Benefit Period** as shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE.

To calculate the accumulated **Annual Aggregate Deductible**:
1. multiply the number of **Covered Units** for each month of the **Policy Period** by the appropriate monthly Aggregate **Deductible** Factor(s) as shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE to obtain the Monthly Aggregate **Deductible** for each month; and
2. add the Monthly Aggregate **Deductible** for each month of the **Policy Period**.

To calculate the accumulated Minimum **Annual Aggregate Deductible**:
1. multiply the number of initial **Covered Units** as shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE by [100%]; and
2. multiply by the Monthly Aggregate **Deductible** Factor(s) as shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE; and
3. multiply by the number of months which have been accumulated in the **Policy Period**.

The number of initial **Covered Units** is subject to change based on the actual number of **Covered Units** for the first (1st) month of the **Policy Period**.

The Aggregate Stop Loss Benefit for the **Policy Period**, or fraction thereof, is the Eligible **Plan Benefits** which are **Incurred** and **Paid** within the **Benefit Period** as shown in SCHEDULE OF INTEGRATED STOP LOSS INSURANCE:

1. less amounts in excess of the **Lifetime Limit of Liability** per **Covered Person** as shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE; and
2. less the greater of the **Annual Aggregate Deductible** or fraction thereof or the Minimum **Annual Aggregate Deductible** or fraction thereof; and
3. multiplied by the Aggregate **Percentage Reimbursable** as shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE[, and not exceeding the Limit of Liability for the **Policy Period** as shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE].

The **Policyholder** will repay to the **Company**, on a [monthly] basis, any and all amounts in excess of [$1,000.00] and which were advanced to and paid under the Aggregate Stop Loss Coverage in which the Eligible **Plan Benefits** are less than the sum of the Monthly Aggregate **Deductible**. The **Policyholder** will repay the **Company** the difference between these two amounts, within [ten (10)] days of the **Company's** request. If at the end of the **Policy Period**, Eligible **Plan Benefits** do not exceed the **Annual Aggregate Deductible**, the **Policyholder** will repay the **Company** any amounts paid under the Aggregate Stop Loss Coverage within [ten (10)] days of the **Company's** request. If repayment in full is not made when due, the **Company** will be entitled to assess monthly a late payment fee equal to [1.5%] of the outstanding balance.

SECTION V

TERM OF POLICY

This **Policy** will be in force during the **Policy Period** shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE and will automatically terminate at the end of the **Policy Period** unless it has been terminated earlier as provided in the TERMINATION provision, or unless the **Company** and the **Policyholder** have agreed upon terms to renew the **Policy**. In such event, the **Company** will issue to the **Policyholder** a new **Policy** or a renewal endorsement and SCHEDULE OF INTEGRATED STOP LOSS INSURANCE.

SECTION VI

PREMIUMS AND AGGREGATE FACTORS

The SCHEDULE OF INTEGRATED STOP LOSS INSURANCE shows the premium rates for each coverage and the Monthly Aggregate **Deductible** Factors for Aggregate Stop Loss Coverage. The initial premium is due on the Effective Date of this **Policy** and subsequent premiums are due on the first (1^{st}) day of each succeeding month in the **Policy Period**. The entire amount of the applicable premium shall be paid when due. The **Company** is not obligated to accept or apply any premium paid which is less than the entire amount due for any period. Premium payments shall be credited first to any past due and unpaid premium, in the order in which due. Premiums are not considered paid until the premium payment is received by the **Company**.

A grace period of [thirty-one (31)] days is allowed for the payment of any premium except the first. The **Company** is not obligated to apply any premium which is received after the grace period and may, at its discretion, return any premium payment. The payment of any premium will not cause the insurance under this **Policy** to remain in force beyond the day before the next Premium Due Date.

The **Company** may change the premiums and Monthly Aggregate **Deductible** Factors on any of the following dates:

1. The effective date that the **Plan** is amended; or
2. The effective date that the **Policyholder** adds or deletes a subsidiary or affiliated companies or divisions; or
3. The date an increase or decrease in the number of **Covered Units** exceeds [10%] in any one month or [15%] from the number of **Covered Units** on the first (1^{st}) day of the **Policy** effective date; or
4. The date that the **Company** is informed of a clerical error or discovers material misrepresentation of underwriting information. The **Company's** action will be in accordance with the Misstated Data Provisions under the GENERAL PROVISIONS of this **Policy**; or
5. The effective date that the **Provider Network(s**) is changed.

The **Policyholder** will furnish to the **Company** any information which the **Company** deems necessary to determine the amount of premium due under this **Policy**. The **Company** may, at its discretion, examine any records of the **Policyholder** at any reasonable time to confirm that premiums are being calculated and paid in accordance with this **Policy**. The **Company** will refund to the **Policyholder** any overpayment of premium made in error. Such refund shall be made only for the overpayments made during the **Policy Period** in which the error is uncovered and reported to the **Company**.

SECTION VII

CLAIM PROVISIONS

The **Policyholder** warrants, upon presentation of a **Plan Benefit** for reimbursement, that all monies necessary to pay for the **Plan Benefit** have been **Paid** to the **Covered Person** or the provider of services to the **Covered Person**.

The **Policyholder** will maintain records showing the complete details concerning any and all amounts paid for benefits not provided under the terms of the **Plan**. These payments for benefits not provided under the terms of the **Plan** will not be included in determining **Plan Benefits** reimbursable under this **Policy**.

The **Policyholder** or **Third Party Administrator** will give written notice of claims to the **Company** on the **Company's** customary **Proof of Loss** form within [thirty-one (31)] days of the date the **Policyholder** or **Third Party Administrator** becomes aware [or by the exercise of reasonable due diligence should have become aware] of the existence of facts which would reasonably suggest:

1. the possibility that **Plan Benefits** will be **Incurred** by a **Covered Person** and which are subject to this **Policy** and will result in claims of at least [$15,000.00]; or
2. the **Covered Person** has been diagnosed with or treated for any of the codes listed in the **Policyholder** Disclosure Statement.

The **Policyholder** or **Third Party Administrator** will submit written **Proof of Loss**, in a form and content satisfactory to the **Company**, within [thirty-one (31)] days of the date that **Plan Benefits** exceed [$30,000.00] for a **Covered Person** and which are **Incurred** and **Paid** during the **Benefit Period** as shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE.

The **Policyholder** or **Third Party Administrator** will also comply with other claim reporting requirements, provided the **Company** sends written notice to the **Policyholder** or **Third Party Administrator** of these requirements and allows the **Policyholder** or **Third Party Administrator** [thirty (30)] days to begin complying with the new requirements. [Failure to furnish written notice or **Proof of Loss** will not invalidate or reduce any claim if it was not reasonably possible to provide such written notice or **Proof of Loss** within the time period(s) required.] [If the **Company** determines it was reasonably possible to provide written notice or **Proof of Loss** in accordance with the time period(s) required, the **Company** may adjust the reimbursement to reflect savings the **Company** may have obtained had the **Company** received written notice or **Proof of Loss** within [thirty-one (31)] days.]

In no event will the **Company** be liable for any claims submitted for reimbursement more than [twelve (12)] months after the end of the **Benefit Period**.

OFFSET
The **Company** has the right to offset any benefits payable to the **Policyholder** under this **Policy** against premiums due and unpaid by the **Policyholder**. This right will not prevent the termination of this **Policy** for the non-payment of premium under the Termination Provision of this **Policy**.

SECTION VIII

EXCLUSIONS AND LIMITATIONS

The following expenses are not covered:

1. Expenses not specifically covered under the terms of the **Plan**.

2. Expenses **Incurred** by an individual who is not a **Covered Person** under the **Plan** when the expense was **Incurred**.

3. Expenses **Incurred** when the **Plan** is not in effect.

4. Expenses **Paid** by the **Policyholder** to the extent the **Policyholder** receives payments for those expenses from other insurers.

5. Charges for cosmetic surgery, unless from a congenital defect, or the **Plan** is required to provide coverage under federal law.

6. Expenses for the cost of any **Experimental or Investigational Treatment**, procedure, service, supply, or drug, unless all of the criteria as shown in SECTION III DEFINITIONS are met.

7. Expenses for the cost of any treatment, procedure, service, supply, or drug which is not **Medically Necessary and Appropriate**.

8. Expenses of persons who were not reported on the Policyholder Disclosure Statement who should have been disclosed in compliance with the terms of the Policyholder Disclosure Statement.

9. Expenses for benefits which the **Policyholder** is not legally liable to pay under the **Plan**.

10. Expenses also covered as benefits under Medicare or another health insurance plan. In no event will total payments on behalf of a **Covered Person** for a reimbursement otherwise payable under this **Policy** and any similar Medicare benefit or a benefit under another health insurance plan exceed one hundred percent of the **Covered Person's Eligible Claim Expenses**.

11. Expenses which are covered under Medicare or another health insurance plan for which the **Policyholder** is not liable under coordination of benefits, non duplication or other provisions in the **Plan**.

12. Expenses resulting from:
    a. extra or non-contractual damages including compensatory, exemplary or punitive damages; or
    b. legal fees and expenses related to the operation of the **Plan**, including the defense of claims and appeals; or
    c. fines for statutory penalties awarded as a result of an act, omission or course of conduct committed by or for which the **Policyholder** was held responsible in connection with the **Plan**; or
    d. cost of the administration of claim payments, consulting fees, administration fees, or other services provided on behalf of the **Policyholder** by a third party.

13. Charges for any accidental bodily injury or sickness for which the **Covered Person** would be entitled to benefits under any Workers' Compensation or Occupational Disease Law whether or not the **Covered Person** claims his or her rights to such benefits.

14. Expenses related to **War**.

15. Expenses resulting from **Provider Network** discounts and/or prompt pay or negotiated discounts that were lost as a result of the **Policyholder's** failure to pay a provider in a timely manner or for any other reason.

16. Expenses resulting from liability or obligations assumed by the **Policyholder** or **Third Party Administrator** under any contract or service agreement other than the **Policyholder's** self-funded benefit **Plan(s)**.

17. Taxes. The payment of reimbursement under this **Policy** will not include:
    a. any taxes which might be paid or payable by the **Policyholder**; or
    b. any tax liability, interest, or penalty imposed by any regulatory or taxing authority.

    In addition, the **Policyholder** agrees to:
        1) hold harmless the **Company** from any tax liability assessed against the **Company** on the basis of the coverage provided under the **Plan** other than any tax levied upon the **Company** for the premium due under this Policy; and

2) reimburse the **Company** for the amount of any such tax liability, interest, penalty, or cost incurred by the **Company** as the result of such tax assessment. Such reimbursement shall be due and payable when the **Policyholder** receives the **Company's** notification that reimbursement is due.

18. [Expenses related to drug and alcohol addiction [or mental illness] shall be limited to the underlying **Plan** maximum].

19. [Expenses relating to:
    a. non-human organ/tissue transplants; or
    b. invitro-fertilization; or
    c. expenses relating to radial keratotomy; or
    d. expenses relating to reversal of voluntary sterilization; or
    e. gene therapy; or
    f. cloning]

20. [Charges billed by a hospital or facility, which are in excess of:
    a. [the manufacturer's invoice plus [20]% for medical/surgical supplies and devices billed under the following revenue codes, as published by the National Uniform Billing Committee, including but not limited to:
        1) 274 - Prosthetic/orthotic devices
        2) 275 - Pacemaker
        3) 276 - Intraocular lens
        4) 277 - Other implants
        5) 278 - Other supplies/devices
        6) 279 - Other supplies/devices

        If the manufacturer's invoice is not made available to the **Company**, charges billed under the above revenue codes will be limited to the manufacturer's suggested retail price plus [20]%.]

    b. [the average wholesale price (AWP) for prescription drugs billed under the following revenue codes, as published by the National Uniform Billing Committee, including but not limited to:
        1) 250 - General
        2) 251 - Generic drugs
        3) 252 - Nongeneric drugs
        4) 253 - Take-home drugs
        5) 259 - Other pharmacy
        6) 630 - General
        7) 631 - Single source drug
        8) 632 - Multiple source drug
        9) 633 - Restrictive prescription
        10) 634 - Erythropoietin (EPO) less than 10,000 units
        11) 635 - Erythropoietin (EPO) 10,000 or more units
        12) 636 - Drugs requiring detailed coding
        13) 637 - Self-Administrable drugs

        The average wholesale price allowable will be based on the most current version of [RED BOOK by Thomson Micromedex.]

21. [Charges in excess of the **Reasonable and Customary Charge**, whether or not the service or supply was rendered by a provider participating in a **Provider Network(s)**.]

SECTION IX

TERMINATION

By the Policyholder
The **Policyholder** may terminate this **Policy** on any Premium Due Date by giving the **Company** at least [thirty-one (31)] days advance written notice.

By the Company

At its option, the **Company** may terminate this **Policy** on the date that any one of the following occurs:

1. in the event that the **Policyholder** has failed to perform any of the duties or obligations under this **Policy**, the **Company** will provide the **Policyholder** with a written notice specifying such acts or omissions and will have the right to terminate the **Policy** if the **Policyholder** does not rectify such failures within [ten (10)] days of the receipt of the written notice; or
2. a petition in bankruptcy court is filed, with respect to the **Plan** or the **Policyholder**, whether voluntary or involuntary, or the **Plan** or the **Policyholder** becomes subject to liquidation, receivership or conservatorship; or
3. whenever the percentage of employees participating in one or more Health Maintenance Organizations, prepaid plans, or insurance plans exceeds [40%] of employees eligible to participate in the **Plan**, unless the **Company** has agreed in writing to continue coverage; or
4. the number of lives falls below the minimum number of lives and/or participation as shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE; or
5. the date the **Plan** is found to be in violation of federal law; however, if it is determined that the **Plan** is not in compliance with such laws, the **Company** will allow the **Policyholder** [ninety (90)] calendar days within which to achieve compliance. Failure to comply by such date will result in termination of the **Policy** as of the date the **Plan** was found to be in violation; or
6. upon giving the **Policyholder** at least [thirty (30)] days advance written notice.

Automatic

This **Policy** will automatically terminate without notification required upon the earliest of the following dates:

1. the date the **Plan** terminates; or
2. at the end of any grace period when the premium due remains unpaid as of the premium due date; or
3. the date the **Policyholder** has failed to provide funds for payment of claims under the **Plan**; or
4. delegation by the **Policyholder** of its duties under this **Policy** to a **Third Party Administrator** which has not been approved by the **Company**; or
5. [sixty (60)] days after the Effective Date if the **Policyholder** has failed to furnish the **Company** with any information or materials requested by the **Company**. Such information or materials must be of reasonable nature to allow the **Company** to determine its liability under this **Policy**. If the **Policy** is terminated under this provision, the **Company's** sole liability will be to return any monies given by the **Policyholder** as consideration for this **Policy** and less any claims or other expenses paid by the **Company** under this **Policy**. If such amounts paid by the **Company** are greater than the amount of the refund due the **Policyholder**, the **Policyholder** shall pay the amount of the deficit to the **Company** within [thirty (30)] days of notice from the **Company**. If repayment in full is not made within this [thirty (30)] day period, the **Company** will be entitled to assess monthly a late payment fee equal to [1.5%] of the outstanding balance.

Effect of Termination

In the event that this **Policy** is terminated by the **Policyholder** or by the **Company** under paragraphs (1), (2), (3), or (4) of the preceding paragraph under the caption **Automatic**, the Minimum Annual Premium as shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE shall be due and payable to the **Company**.

The **Company** has no obligation to reimburse the **Policyholder** for any **Plan Benefits** which are **Paid** after the date this **Policy** terminated.

SECTION X

GENERAL PROVISIONS

Entire Policy

The entire **Policy** consists of this **Policy**, the attached copy of the **Policyholder's** [Renewal] Application for Integrated Stop Loss Insurance Coverage, the Policyholder Disclosure Statement and any amendments, riders or endorsements.

Changes to the Policy

This **Policy** may be changed at any time by a written agreement between the **Policyholder** and the **Company**. The provisions of this **Policy** may be changed or waived only by the President, a Vice President, or the Secretary of the **Company** and only in writing. The **Company** will not be bound by any promise or representations made by any other person. The **Company** may change any one or more or all of the items shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE by endorsement during the **Policy Period** in response to any change which is made to any

applicable state or federal law which change, in the sole opinion of the **Company**, may affect the **Company's** liability under this **Policy**.

Parties to the Policy
This **Policy** is a contract between the **Policyholder** and the **Company**. This **Policy** does not create any right or legal relationship between the **Company** and any person covered under the **Plan**. The **Company's** sole liability under this **Policy** is to the **Policyholder**. Any and all reimbursements payable under this **Policy** will be made solely to the **Policyholder**. This **Policy** will not be deemed to make the **Company** a party to any contract or agreement between the **Policyholder** and a third party.

Plan Document
The **Policyholder** will provide to the **Company** a complete copy of the **Plan** document governing the **Plan**. The **Policyholder** will submit to the **Company**, in writing, any proposed change to the provisions of the **Plan**. This must be submitted to the **Company** at least [thirty (30)] days prior to the effective date of the proposed change. The **Company** will have the right to modify premium rates and/or Monthly Aggregate **Deductible** Factors if the **Company** determines that its liability under this **Policy** has been affected by the change in the **Plan**. If the **Company** and the **Policyholder** cannot reach agreement with respect to the **Plan** changes, the **Plan** change will not affect the **Company's** liability under this **Policy** and the **Policy** will be administered as if the **Plan** had not changed. The **Company's** liability under the **Policy** will not be affected by any such changes made to the **Plan** unless and until the **Company** has sent its written approval of such changes to the **Policyholder** or its agent.

Third Party Administrator
The **Policyholder** may retain a **Third Party Administrator** to perform some or all of its duties under this **Policy**. Such **Third Party Administrator** must be named in the [Renewal] Application for Integrated Stop Loss Insurance Coverage which is attached to and made part of this **Policy**. The **Third Party Administrator** must be approved by the **Company** to perform the **Policyholder's** duties under this **Policy**. The **Policyholder** will provide to the **Company** a copy of its agreement with the **Third Party Administrator** as well as a copy of changes thereto. These documents are NOT made part of this **Policy**.

Without waiving any of its rights under this **Policy**, and without making the designated **Third Party Administrator** a party to this **Policy**, the **Company** agrees to recognize the **Third Party Administrator** as the agent for the **Policyholder**. The **Third Party Administrator** is NOT the agent of the **Company**. Notwithstanding its appointment of a **Third Party Administrator**, the **Policyholder** is still obligated to see to the timely performance of its duties and obligations under this **Policy**. Furthermore, the **Policyholder** will hold the **Company** harmless from any liability arising from or related to any negligence, error, omission, or malfeasance by the **Third Party Administrator**.

The **Policyholder** may change its **Third Party Administrator** to a **Third Party Administrator** acceptable to the **Company**. The **Policyholder** must provide written notice to the **Company** at least [sixty (60)] days prior to the effective date of change. Any changes to the designated **Third Party Administrator** without prior written approval by the **Company** will cause this **Policy** to automatically terminate as provided for in the TERMINATION provision.

Reporting
The **Policyholder** will submit by the [fifteenth (15^{th})] day of each month all proofs, reports, and supporting documents requested by the **Company**, including but not limited to, a monthly summary of all eligible claim payments processed by the **Policyholder** and the total number of **Covered Units** covered under the **Plan** during the prior month. The **Policyholder** will be responsible for the investigation, audit, calculation, and payment of all claims incurred under the **Plan**.

The **Policyholder** will furnish the **Company** with information required by the **Company** pertaining to the risks covered under this **Policy**. Such information must be received by the **Company** in a form and during a time period satisfactory to the **Company**.

Records
The **Policyholder** will maintain records of all **Covered Persons** under the **Plan** during the **Policy Period** and for a period of [seven (7)] years after termination of the **Policy**. The **Policyholder** will make all such records available to the **Company** as needed for the **Company** to determine its liability under this **Policy**.

Audit

The **Company** or its authorized representative will have the right to audit, at its own expense, the records of the **Policyholder**, the **Third Party Administrator** or any other person who is responsible for the administration of the **Plan** pertaining to the matters which affect the **Company's** liability under this **Policy**. The **Policyholder** agrees that payment of any reimbursements under this **Policy** will be conditioned upon the results of any audit requested by the **Company**.

Clerical Error
Clerical error, whether by the **Policyholder** or the **Company**, in keeping any records pertaining to the coverage, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated. Any clerical error in data that the **Policyholder** or its agent provided to the **Company** must be corrected and promptly reported to the **Company**. The **Company** will within [fifteen (15)] days of receipt of corrected data decide the corrective course of action under the terms of the MISSTATED DATA provision below.

Concealment, Fraud
This entire **Policy** will be void:
1. if, before or after making any reimbursement, the **Company** determines that the **Policyholder** or its agent has concealed or misrepresented any material fact or circumstance concerning this **Policy**, including any losses under the **Plan**; or
2. in any case of fraud by the **Policyholder** or its agent.

Misstated Data
The **Company** has relied upon the underwriting information provided by the **Policyholder** or its agent in the issuance of this **Policy**. If the **Company** subsequently learns of information which was known but not disclosed prior to the issuance of the **Policy**, and such information would have affected the premium rates, Monthly Aggregate **Deductible** Factors, Aggregate **Deductible**, terms, or any other conditions for coverage, the **Company** will have the right to:
1. rescind the **Policy** as of the Effective Date. In the event of **Policy** rescission, the **Company's** sole liability will be to return any monies received from the **Policyholder** as consideration for this **Policy** and less any claims or other expenses paid by the **Company** under this **Policy**. If such amounts paid by the **Company** are greater than the amount of the refund due the **Policyholder**, the **Policyholder** shall pay the amount of the deficit to the **Company** within [thirty (30)] days of notice from the **Company**. If repayment in full is not made within this [thirty (30)] day period, the **Company** will be entitled to assess monthly a late payment fee equal to [1.5%] of the outstanding balance; or
2. adjust the premium rates, Monthly Aggregate **Deductible** Factor, **Annual Aggregate Deductible**, terms or any other conditions for coverage as of the Effective Date by providing written notice to the **Policyholder**.

Insolvency
The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the **Policyholder** or its **Third Party Administrator** will not impose on the **Company** any liability other than the liability defined in this **Policy**. The insolvency of the **Policyholder** will not make the **Company** liable to the creditors of the **Policyholder**, particularly the **Covered Persons** under the **Plan**.

Liability
The **Company** will not have any obligation under this **Policy** to directly pay any **Covered Person** or any provider of services or supplies to a **Covered Person**. The **Company's** sole liability is to the **Policyholder**. Nothing in this **Policy** will be construed to permit a **Covered Person** or any provider of services or supplies to a **Covered Person** to have a direct right of action against the **Company**. The **Company** is not a party to the **Plan** or to any modifications thereto. The **Policyholder** may not assign reimbursements under this **Policy** and the **Company** will not recognize any such assignments.

Provider Network(s)
The **Policyholder** or **Third Party Administrator** will provide to the **Company** a complete listing of **Provider Network(s)**. [The **Policyholder** or **Third Party Administrator** will provide the **Company** with the corresponding **Provider Network(s)** contract(s), upon request.] The **Policyholder** or **Third Party Administrator** must submit to the **Company**, in writing, any proposed change in their **Provider Network(s)**. This must be submitted to the **Company** at least [sixty (60)] days prior to the effective date of the change. The **Company** will have the right to modify premium rates and/or Monthly Aggregate **Deductible** Factors if the **Company** determines that its liability under this **Policy** has been affected by the change in the **Provider Network(s)**. The **Company's** liability under the **Policy** will not be affected by any such changes made to the **Provider Network(s)** unless and until the **Company** has sent its written approval of such changes to the **Policyholder** or its agent.

Notice
For the purpose of any notice required from the **Company** under the provisions of this **Policy**, notice to the **Third Party Administrator** will be considered notice to the **Policyholder**, and notice to the **Policyholder** will be considered notice to the **Third Party Administrator**. For the purpose of any notice requirement from the **Policyholder** under the provisions of this **Policy**, neither notice from the **Policyholder** to the **Third Party Administrator** nor notice from the **Third Party Administrator** to the **Policyholder** will be considered notice to the **Company**.

Subrogation
The **Company** has the right to recover any and all payments that the **Company** has made to the **Policyholder** under this **Policy** from any person or entity that has been found to make, or is obligated to make in the future, a First and/or Third Party payment to a **Covered Person** as the result of an accident or illness caused by the negligence of another party. If the **Policyholder** recovers any monies from any source for any loss for which the **Policyholder** received payment under this **Policy**, the **Company** will be reimbursed on a priority basis from such recovery to the extent of the **Company's** payments to the **Policyholder** before the **Policyholder** is entitled to a recovery. This obligation of the **Policyholder** to the **Company** survives the termination of this **Policy** and is applicable even if the **Policy** has expired and/or been terminated.

In the event the **Policyholder** does not pursue all available recovery sources, then the **Policyholder's** right of subrogation against a **Covered Person** transfers to the **Company** and the **Policyholder** will at all times cooperate with the **Company** in their recovery efforts. Further, there can be no deduction of the amounts due the **Company** for legal fees, or any costs associated with the recovery of these payments without the express written agreement of the **Company** prior to the matter being settled or these costs being incurred. In addition, if there is to be a settlement for any portion of the funds that is less than 100% of the amounts(s) paid to the **Policyholder** by the **Company**, any such agreement must first be approved by the **Company**, or its designated representative, before the **Policyholder** agrees to such a settlement with any other person or entity.

Other Insurance
The amounts otherwise payable under this **Policy** shall be reduced by the amount of any reimbursement or indemnity which the **Policyholder** may be entitled to receive with respect to the **Company's** liability under this **Policy**.

Waiver
Failure of the **Company** to strictly enforce its rights under this **Policy** shall not waive any such right, regardless of the frequency or similarity of the circumstances.

Conformity to Statute
Any part of this **Policy** that conflicts with state law is automatically changed to conform to that law.

Hold Harmless
The **Policyholder** agrees to indemnify and hold the **Company** harmless for any amounts paid or incurred for legal expenses, costs, reasonable settlements, or judgments arising out of any dispute involving a **Covered Person** or by any third party; provided that such legal expenses, costs, settlements, or judgments were not incurred as a result of the sole negligence or intentional wrongful acts of the **Company**.

Suit Against the Company
No suit, action or proceeding against the **Company** for the recovery of any claim will be sustained in any court of law or equity unless the **Policyholder** has fully complied with all the provisions of this **Policy** and legal action is started within [twelve (12)] months after the end of the **Benefit Period**.

If under the insurance laws of the applicable jurisdiction such [twelve (12)] months limitation is invalid, then any such legal action needs to be started within the shortest limit of time permitted by such laws.

Policyholder Disclosure Statement

Zurich American Insurance Company

INSTRUCTIONS FOR COMPLETING THE ATTACHED DISCLOSURE FORM

The Health Insurance Portability and Accountability of Act of 1994 (HIPAA) permits the release of Protected Health Information (PHI) for the purpose of evaluating and accepting risk associated with the **Policyholder** as a part of "health care operations". The **Company** shall use the information provided solely for the purpose of evaluating the acceptability of this risk and shall not disclose any Protected Health Information collected except in performing this risk evaluation.

The **Company** will rely upon the information provided on the attached disclosure form, which will become part of the **Policy** for Integrated Stop Loss coverage. The purpose of the form is to allow the **Company** to take underwriting action on all known risks in the categories listed below. It is the **Policyholder's** responsibility, either directly or through its designated representative, to accurately report all claims known as of the date of this disclosure by making a thorough review of all applicable records. Such records shall include historical claims reports, disability records, current information from administrators, insurers, utilization management companies, managed care companies, and any agent/broker of the **Policyholder**. In exchange, the **Company** will accept the liability for any truly unknown risks. The attached disclosure form must be completed and signed by the appropriate parties no more than [thirty (30)] days prior to the proposed Effective Date of Integrated Stop Loss coverage and received by the **Company** within [five (5)] days of completion.

Upon receipt of the completed disclosure, the **Company** will assess all data, new and previously reported, and will inform the producer in writing within [five (5)] days of any changes to the rates, factors or terms of coverage. The **Company** reserves the right to rescind the proposal in its entirety based upon a review of all information submitted during the proposal process.

List on the Disclosure Form all persons who are known to:

1. Be currently confined to a medical facility, or have been pre-certified for same within the last three months.
2. Have received medical services during the past twelve months the cost of which exceeds [$15,000] and for which bills have been received by the claims administrator and entered into the claims system.
3. Have been identified as a candidate for case management and as having the potential to exceed [$15,000] during the policy period.
4. Have been diagnosed within the past twelve months, with a condition represented by any of the ICD-9 codes contained in the attached list [and have also received medical services costing $5,000 during the same period]

If the **Policyholder** fails to disclose any risk known to fall into one of the above categories either intentionally or because a thorough review of all available records was not conducted, then the **Company** will have no liability for claims on the risk not disclosed.

THIS INFORMATION WILL BE TREATED CONFIDENTIALLY

Disclosure Form

Risk Identifier	DOB	Sex	EE, Sp or Ch	(A)ctive, (C)OBRA, (R)etiree, or (T)ermed	Term Date	Diagnosis	Most Re-cent Date of Service	Expenses Incurred This Plan Year

The Plan Sponsor named below represents that the above list accurately discloses all potentially catastrophic risks in accordance with the instructions attached to this form and that it is the result of a diligent search in accordance with those instructions. **If there are no risks to report, which meet the disclosure criteria above, please check this box.** ☐

Plan Sponsor:_____ Claims Administrator:_____ Agent/Broker:_____

Signature:_____ Signature:_____ Signature:_____

Name:_____ Name:_____ Name:_____

Title:_____ Title:_____ Title:_____

Date:_____ Date:_____ Date:_____

ICD-9 Codes for Disclosure Notification

Please list all prospective **Covered Persons** or **Covered Persons** of the **Policyholder** who have been diagnosed with or treated for any of the codes listed under the following categories during the current **Benefit Period**:

001-139	***Infectious and Parasitic Diseases***
038-038.9	Septicemia
042	AIDS / ARC
070-070.9	Viral Hepatitis

140-239	***Neoplasms***
140-149.9	Malignant Neoplasm of Lip, Major Salivary Glands, Gum, Mouth, Oropharynx, Nasopharynx, and/or Hypopharynx
150-150.9	Malignant Neoplasm of Esophagus
151-151.9	Malignant Neoplasm of Stomach
153-153.9	Malignant Neoplasm of Colon
154-154.8	Malignant Neoplasm of Rectum
155-155.2	Malignant Neoplasm of Liver
157-157.9	Malignant Neoplasm of Pancreas
161-161.9	Malignant Neoplasm of Larynx
162-162.9	Malignant Neoplasm of Lung
170-170.9	Malignant Neoplasm of Bone
174-174.9	Malignant Neoplasm of Female Breast
179-182.8	Malignant Neoplasm of Uterus or Cervix
183-183.9	Malignant Neoplasm of Ovary
185	Malignant Neoplasm of Prostate
186-186.9	Malignant Neoplasm of Testis
188-189.9	Malignant Neoplasm of Bladder, Kidney, Urinary
191-191.9	Malignant Neoplasm of Brain
192-192.9	Malignant Neoplasm of Nervous System
194-194.9	Malignant Neoplasm of Endocrine Glands
195-195.8	Malignant Neoplasm of Other Ill-Defined Sites
196-196.9	Secondary Malignant Neoplasm Lymph Nodes
197-197.8	Secondary Malignant Neoplasm Respty and Digestive Systems
198-198.89	Secondary Malignant Neoplasm Other Specified Sites
200-208.9	Lymphoma and/or Leukemia
235	Neoplasm Uncertain Behavior
239.2	Neoplasm Unspecified Nature – Bone, Skin

240-279	***Endocrine, Nutritional, Metabolic, Immunity***
250-250.9	Diabetes
277.0	Cystic Fibrosis
278.0	Obesity/Hyperaliment

280-289	***Diseases of the Blood and Blood-Forming Organs***
282.6	Sickle-Cell Anemia
284.9	Aplastic Anemia NOS
286-286.9	Coagulation Defects and/or Hemophilia

320-389	***Diseases of the Nervous System and Sense Organs***
330	Cerebral degenerations
344.0-344.09	Quadriplegia and Quadriparesis
331.0-331.9	Reye's Syndrome
344.1	Paraplegia
348.0-348.9	Encephalopathy
357, 358	Neuropathy / Myasthenia Gravis

390-459	***Diseases of the Circulatory System***
410-410.9	Acute Myocardial Infarction
411-411.89	Acute and Subacute Ischemic Heart Disease
414-414.05	Coronary Atherosclerosis (ASHD)
415-415.19	Acute Pulmonary Heart Disease
416-416.9	Chronic Pulmonary Heart Disease
417.1	Aneurysm of Pulmonary Artery
421-421.9	Acute and Subacute Endocarditis
424-424.9	Valve Disorders
425-425.9	Cardiomyopathy
426-426.9	Conduction Disorders
427-427.9	Cardiac Dysrhythmias
428-428.9	Heart Failure
430, 431	Subarachnoid / Intracerebral Hemorrhage
434.9	Occlusion of Cerebral Arteries
436	Acute Cerebrovascular Accident (CVA)
440-441.9	Atherosclerosis / Aortic Aneurysm

460-519	***Diseases of the Respiratory System***
480-486	Pneumonia
490-496	Chronic Obstructive Pulmonary Disease (COPD), etc.
515	Postinflammatory Pulmonary Fibrosis
518-518.89	Pulmonary Collapse and/or Respiratory Failure

520-579	***Diseases of the Digestive System***
555-555.9	Regional Enteritis (Crohn's Disease)
560.0-560.9	Intestinal Obstruction
562.1	Diverticulitis of Colon
567-567.9	Peritonitis
569.0-569.9	Other Disorders of Intestine
570-571.9	Liver Diseases and Cirrhosis
572.8	Other Sequela of Chronic Liver Disease
573-573.9	Other Liver Disorders
577-577.9	Pancreas Diseases
578-578.9	Gastrointestinal Hemorrhage

580-629	***Diseases of the Genitourinary System***
584-584.9	Acute Renal Failure
585	Chronic Renal Failure
586	Renal Failure, Unspecified
588	Disorders resulting from impaired renal function
592	Calculus of Kidney & Ureter

630-677	***Complications of Pregnancy, Childbirth***
641.1	Placenta Previa
642.5-642.7	Eclampsia, pre-eclampsia
644.0-644.2	Premature Labor
648.0	Gestational Diabetes
651	Multiple Gestation
654.5	Cervical Incompetence

710-739	***Diseases of the Musculoskeletal System and Connective Tissue***
715.0-715.9	Osteoartrhosis
721.3	Lumbosacrel Spondylosis
722.0-722.9	Intervertebral Disc Disorders
730.-730.09	Osteomyelitis and/or Periostitis
737.3	Kyphoscoliosis and scoliosis

740-759	***Congenital Anomalies***
747.2	Aortic Atresia / Stenosis
751.6	Biliary Atresia
759-759.9	Other and Unspecified Congenital Anomalies

760-779	***Conditions Originating in the Perinatal Period***
765-765.1	Prematurity
769	Respiratory Distress Syndrome
770.0-770.9	Other Respiratory Conditions of Newborn

780-799	***Symptoms, Signs, and Ill-Defined Conditions***
785-785.9	Symptoms Involving Cardiovascular System
786.5-786.59	Chest Pain

800-999	***Injury and Poisoning***
800-804.9	Fracture of Skull
805-805.9	Fracture of Vertebral Column
806-806.9	Fracture of Vertebral Column with Spinal Cord Injury
828-828.1	Multiple Fractures
853-854.1	Intracranial Injury
869-869.1	Internal Injury
887-887.7	Traumatic Amputation of Arm and Hand
897-897.7	Traumatic Amputation of Leg
949-949.5	Burns
952-952.9	Spinal Cord Injury
996-997.0	Complications peculiar to certain specified conditions
V23	Supervision of High-Risk Pregnancy
V42-V58.9	Transplants, etc.

Aggregate Terminal Liability
Endorsement

Zurich American Insurance Company

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the Integrated Stop Loss Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

SECTION II -
SCHEDULE OF INTEGRATED STOP LOSS INSURANCE is amended to include the following:

AGGREGATE STOP LOSS

Monthly Terminal Liability Extension Factors: [$442.78 Single] [$1,100.94 Family]

SECTION III -
DEFINITIONS is amended to include the following:

TERMINAL LIABILITY EXTENSION PERIOD means [three (3)] consecutive calendar months immediately succeeding the **Policy Period** as shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE.

TERMINAL LIABILITY EXTENSION AGGREGATE DEDUCTIBLE means the amount arrived at by combining the Aggregate liability for the **Policy Period** and the **Terminal Liability Extension Period** as follows:

a. multiply the Monthly Terminal Liability Extension Factors (indicated above) by the average number of **Covered Units** for the [three (3)] month period immediately preceding the termination date; and
b. multiply by [three (3)]; and
c. add this amount to the **Annual Aggregate Deductible** as shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE.

SECTION IV -
AGGREGATE STOP LOSS is amended to include the following:

Terminal Liability Extension Benefit
If the **Policyholder** terminates the **Plan(s)**, this **Terminal Liability Extension** option shall automatically terminate as of the same date. However, if the **Policyholder** furnishes proof acceptable to the **Company** that it has purchased a conventional fully insured group policy which immediately replaces the terminated **Plan(s)** with substantially similar benefits, the **Company** will extend the Aggregate Stop Loss Coverage for an additional [three (3)] months (the **Terminal Liability Extension Period**) following such **Plan(s)** termination on the following basis:

a. if the **Policyholder's** net **Paid** claims for the **Policy Period** and the **Terminal Liability Extension Period** exceed the **Terminal Liability Extension Aggregate Deductible**, the **Company** will reimburse such excess amount to the **Policyholder**. Net **Paid** claims are based on claims incurred prior to the **Plan's** termination date.
b. any Aggregate Stop Loss reimbursement due will be delayed until a final determination of terminal liability can be made following the **Terminal Liability Extension Period**.
c. the **Policyholder's** obligation is an additional premium of [$1.00] (included in Aggregate Premium) per employee covered during the period the **Policy** is in effect. This premium is due and payable on or before the first (1st) day of each month.

Except for the above, this endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy No. _____

Signed by:  _____

Authorized Representative

_____

Date

Retirees
Endorsement

Zurich American Insurance Company

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the Integrated Stop Loss Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

SECTION III -
DEFINITIONS is amended to include the following:

RETIREE(S) shall have the same meaning as **Covered Person** however this **Policy** will be secondary for any **Retiree(s)** covered by Medicare.

Except for the above, this endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy No. _____

Signed by: _____ _____

Authorized Representative Date

Organ and Tissue Transplant Coverage

Endorsement

Zurich American Insurance Company

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the Integrated Stop Loss Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

SECTION VIII -
EXCLUSIONS AND LIMITATIONS is amended to include the following:

[Any charge which is covered in whole or in part under an organ and/or tissue transplant insurance policy is not an **Eligible Claim Expense** under this **Policy**.]

[Any charge which is covered in whole or in part under the Zurich Company Policy No. xx-xx-xxx is not an **Eligible Claim Expense** under this **Policy**.]

Except for the above, this endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy No. _____

Signed by: _____ _____

Authorized Representative Date

Blank Endorsement

Zurich American Insurance Company

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the Integrated Stop Loss Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

[This endorsement will be used to make the following changes to the **Policy** which are administrative in nature:

(1) changes to the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE page; (2) additions or deletions of a subsidiary of the **Policyholder**; (3) modifications which comply with the variable items in the policy filing such as the Claims Basis]

Except for the above, this endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy No. _____

Signed by:  _____

Authorized Representative

_____

Date

Privacy Notice

Applicable to Zurich North America Commercial Customers
We value the trust of our policyholders and others with whom we do business. This Privacy Notice will provide you with our policy regarding the collection and protection of nonpublic personal information of our present and former policyholders. The member companies of Zurich North America Commercial which are listed below are committed to protecting the privacy and security of nonpublic personal information collected in order to provide quality products and services to our United States policyholders and former policyholders.

This Zurich North America Commercial information policy contained in this notice applies to information collected in connection with products for business, commercial or agricultural purposes and does not apply to information collected in connection with products primarily for personal, family or household purposes.

Categories of Nonpublic Personal Information We Collect
We may collect certain nonpublic personal information when underwriting, administering or servicing an insurance policy, or in handling a claim. It may be collected from such persons or organizations as our affiliates, independent insurance agents, or brokers, a policyholder, a claimant, or a claimant's employer. We may collect nonpublic personal information from persons who witnessed incidents, or persons retained by a claimant or by us in the process of administering or servicing a policy, or handling a claim. Such people might include physicians, attorneys, accountants, repair shops, consumer reporting agencies, and appraisers as permitted or required by law.

Information that may be collected includes, but is not limited to, an individual's name, address, telephone number, social security number, motor vehicle reports, policy number, premium and/or premium payment history, medical history, and credit reports. We also may collect from a claimant the claimant's name, address, telephone number, social security number, claim number, date of loss, type of loss, cause of loss, and the value of claim.

We may also collect nonpublic personal information when you use our corporate web sites. Information is obtained through online collecting devices known as "cookies" (see our Online Privacy Notice at www.zurichna.com).

Categories of Nonpublic Personal Information We Disclose
Nonpublic personal information may be shared with affiliated and nonaffiliated third parties in order to administer or service an insurance policy or a claim, and as otherwise permitted or required by law. Our Affiliates include insurance companies, administrators, investment companies, brokers/dealers and other providers of financial products and services. Examples of unaffiliated third parties include an independent insurance agent or broker, the policyholder, persons or organizations retained to assist in the administration of policies and/or claims (such as appraisers, repair shops and medical providers), insurance support organizations, reinsurers, companies we have joint marketing agreements, and others as permitted or required by law.

Categories of Nonpublic Personal Information Usage
We use nonpublic personal information to underwrite, administer or service a policy, administer a claim, or in connection with billing charges and as otherwise permitted by law. Nonaffiliated third parties that may receive or have access to our nonpublic personal information are not authorized to use such information for any marketing purposes except as permitted by law. They may not copy or disclose nonpublic personal information to any other party and may use it only for the purpose of performing their responsibilities to us, or one of our policyholders, or claimants and as otherwise permitted by law.

Security of Nonpublic Personal Information
We control access to nonpublic personal information to those who need access to provide products and services to policyholders and to others as permitted or required by law. We maintain physical, electronic, and procedural safeguards to better protect against the misuse of nonpublic information under our control.

Modifications to our Privacy Policy
We reserve the right to change our privacy policies in the future, which could include sharing nonpublic personal information with nonaffiliated third parties for purposes other than as stated in this notice. We will provide you a revised privacy notice before we do that. Additional copies of our Privacy Notice may be obtained by submitting a written request

to the following address: Zurich North America Commercial, Specialties Business Unit – Corporate Law Department, One Liberty Plaza, 165 Broadway, New York, NY 10006.

Privacy Notices from Other Zurich Affiliates

Zurich North America Commercial customers may receive other privacy notices from other business units, companies, affiliates and subsidiaries of Zurich Financial Services. Those privacy notices are separate and in addition to this Privacy Notice. The terms of this Privacy Notice do not modify, revise, or amend the terms of other privacy notices received from other business units, companies, affiliates or subsidiaries of Zurich Financial Services.

Zurich North America Commercial Member Insurance Companies

Zurich American Insurance Company
One Liberty Plaza, 165 Broadway
New York, New York 10006
Licensed in: All states including DC, PR, U.S. Virgin Islands

Not all products and services are provided by all insurance companies in all states and are not available in a state in which an insurance company is not licensed, except as otherwise permitted.

SERFF Tracking Number:	*ZURC-125756620*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*39810*
Company Tracking Number:	*CW-AH-27574*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing*		
Project Name/Number:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing/CW-AH-27574*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ZURC-125756620*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*39810*
Company Tracking Number:	*CW-AH-27574*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing*		
Project Name/Number:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing/CW-AH-27574*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice
Review Status: Approved-Closed 08/16/2008
Comments:
Attachment:
7-31-08 AR Cert.pdf

Bypassed -Name: Application
Review Status: Approved-Closed 08/16/2008
Bypass Reason: N/A
Comments:

Bypassed -Name: Health - Actuarial Justification
Review Status: Approved-Closed 08/16/2008
Bypass Reason: N/A
Comments:

Bypassed -Name: Outline of Coverage
Review Status: Approved-Closed 08/16/2008
Bypass Reason: N/A
Comments:

Satisfied -Name: Statement of Variables
Review Status: Approved-Closed 08/16/2008
Comments:
Attachment:
Statement of Variables.pdf

Satisfied -Name: Readability
Review Status: Approved-Closed 08/16/2008
Comments:
Attachment:
Readability.pdf

SERFF Tracking Number:	*ZURC-125756620*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*39810*
Company Tracking Number:	*CW-AH-27574*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing*		
Project Name/Number:	*CW-AH-27574 2008 Integrated Stop Loss Form & Rate Filing/CW-AH-27574*		

Satisfied -Name: Explanatory Memo

Review Status: Approved-Closed 08/16/2008

Comments:

Attachment:

Explanatory Memorandum.pdf

Satisfied -Name: Cover Letter

Review Status: Approved-Closed 08/16/2008

Comments:

Attachment:

Cover Letter.pdf

Arkansas Certification

This is to certify that the attached U-ISL-100-A CW (06/08) has achieved a Flesch Reading Ease Score of 55.2 and complies with the requirements of Ark. Stat. Ann. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

(Signed by Officer of Company)

Denise Goode
Name Denise Goode
Assistant Secretary
Title

Statement of Variables

Zurich American Insurance Company
Schaumburg, Illinois

INTEGRATED STOP LOSS POLICY

Cover Page

Policyholder: [ ]	Name of Policyholder including subsidiary companies.
Policy Number: [ ]	Policy Number of Policy.
Effective Date: From: [ ] To: [ ]	Effective date and termination date of Policy.
This **Policy** is governed by the laws of the State of [____]	State where Policyholder is located.

SECTION I – APPLICATION FOR INTEGRATED STOP LOSS INSRUANCE COVERAGE

[Renewal]	This will be in or out.

SECTION II – SCHEDULE OF INTEGRATED STOP LOSS INSURANCE

Enrollment (**Covered Units**) at Effective Date:	
[Employees]	The range will be 25 - 500.
[Single]	The range will be 0 - 500.
[Family]	The range will be 0 - 500.
Policy Period from [ ] through [ ]	The dates the Policy will be in effect.
Minimum number of lives and/or participation:	The range will be 25 - 500.

SECTION II – AGGREGATE STOP LOSS

Claims Basis:	
Incurred and Paid [12/12]	Varies by coverage selected, e.g. 5/5, 9/9, 12/12
Run-In [15/12]	Varies by coverage selected, e.g. 36/12, 24/12, 18/12.
Run-Out [12/15]	Varies by coverage selected, e.g. 12/15, 12/18, 12/24.
[Other]	Varies by coverage selected, e.g. 11/14, 14/11, 5/8.
Benefit Period: **Incurred** from [ ] to [ ] **Paid** from [ ] to [ ]	Period in which claims are Incurred and Paid.
[It is hereby understood and agreed…Only **Plan Benefits** that are both **Incurred** and **Paid** by the **Policyholder** within the [12] month **Policy Period** are reimbursable…]	This will be in if the Applicant selects an Incurred and Paid Claims Basis. Varies by coverage selected, e.g. 5, 9, 12
[It is hereby understood and agreed…Only **Plan Benefits** that are both **Incurred** and **Paid** within the **Benefit Period** are reimbursable…]	This will be in if the Applicant selects a Run-In (15/12), Other Run-In (e.g. 14/11), or Paid Claims Basis.
Aggregate **Percentage Reimbursable**: [100%]	This will be in our out. If in, the range will be 5%-100%.
[**Plan Benefits** for…at **Policyholder's** facilities… [80%]	This will be in or out. If in the range will be 0%-80%.
Plan Benefits for…at outside facilities…[100%]]	The range will be 0%-100%.
Monthly Aggregate **Deductible** Factors:	
[$275.00 Employee/Composite]	Varies by calculation.
[$150.00 Single]	Varies by calculation.
[$350.00 Family]	Varies by calculation.

Minimum **Annual Aggregate Deductible**:	
[$900,000]	Varies by calculation.
[90%]	The range will be 80%-100%.
Lifetime Limit of Liability per **Covered Person**:	
[$1,000,000]	The range will be $1,000,000 - $5,000,000.
[Limit of Liability for the **Policy Period**: [$5,000,000]]	This will be in or out. If in, the range will be $1,000,000 to $10,000,000.
[**Plan Benefits Incurred** prior to the **Policy Period** will be limited to $]	This will be in or out and the amount varies by calculation.
SECTION II – PREMIUMS	
Aggregate:	
[Monthly]	Will be either bi-weekly, monthly, bi-monthly, or annually.
[$2.75 Employee]	Varies by calculation.
[$5,000 Annual]	Varies by calculation.
[Minimum Annual Premium:]	This will be in or out.
[$50,000]	Varies by calculation and the range will be $0.00-$1,000,000.
[Aggregate Terminal Liability:]	This will be in or out.
[1.00 Employee]	Varies by calculation and the range will be $0.00-$5.00
SECTION II – ENDORSEMENTS INCLUDED	
[Aggregate Terminal Liability]	This will be in or out.
[Other]	This will be in or out.
SECTION II – INSURANCE FRAUD WARNING	
[Any person who with intent to defraud…is guilty of insurance fraud and is subject to criminal and/or civil penalties.]	Varies by State
SECTION III – DEFINITIONS	
COVERED BENEFITS	This will be in or out.
[Benefits for occupational accidents and illness and fees for administration purposes are not **Covered Benefits**.]	
INCURRED	
[; or (3) with respect to disability income benefits, on the date each periodic benefit payment becomes payable to the Covered Person]	This will be in or out.
POLICYHOLDER	
[Renewal]	This will be in or out.
[**REASONABLE AND CUSTOMARY CHARGE**…]	This will be in or out. If in:
[published by [Ingenix]	The R&C data tables will be as published by Ingenix, Captiva, McKesson, or other reputable vendor.
[maintained by the **Policyholder's Third Party Administrator**]	This will be in or out.
or 3) the [90th] percentile	The range will be 50%-100%.
SECTION IV – AGGREGATE STOP LOSS	
During the **Policy Period** and while this **Policy** is in force,	

on a [weekly] basis, the **Company** will advance to and pay to the **Policyholder** as a loan the Aggregate Stop Loss reimbursement, if any, within [four (4)] days after the **Company's** acceptance of the **Proof of Loss** …	The range will be weekly, bi-weekly, or monthly. The range will be 2 - 14 days.
3. …[, and not exceeding the Limit of Liability for the **Policy Period** as shown in the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE].	This will be in or out.
The **Policyholder** will repay to the Company, on a [monthly] basis, any and all amounts in excess of [$1,000.00] and which were advanced to and paid under the Aggregate Stop Loss Coverage in which the Eligible Plan Benefits are less than the sum of the Monthly Aggregate Deductible. The Policyholder will repay the Company the difference between these two amounts, within [ten (10)] days of the Company's request. If at the end of the Policy Period, Eligible Plan Benefits do not exceed the Annual Aggregate Deductible, the Policyholder will repay the Company any amounts paid under the Aggregate Stop Loss Coverage within [ten (10)] days of the Company's request. If repayment in full is not made when due, the Company will be entitled to assess monthly a late payment fee equal to [1.5%] of the outstanding balance.	The range will be monthly, bi-monthly, or quarterly. The range will be $1,000 - $10,000. The range will be 5 - 30 days. The range will be 5 - 30 days. The range will be 1% - 2%.
SECTION VI – PREMIUMS AND AGGREGATE FACTORS	
A grace period of [thirty-one (31)] days	The range will be 31 - 90 days.
3. The date an increase or decrease in the number of **Covered Units** exceeds [10%] in any one month or [15%] from the number of **Covered Units** on the first (1st) day of the **Policy** effective date	The range will be 10% - 30%. The range will be 10% - 30%.
SECTION VII – CLAIM PROVISIONS	
Proof of Loss form within [thirty-one (31)] days	The range will be 10 - 90 days.
[or by the exercise of reasonable due diligence should have become aware]	This will be in or out.
and will result in at least [$15,000.00]	The range will be $5,000 - $50,000.
Proof of Loss, in a form and content satisfactory to the **Company**, within [thirty-one (31)] days of the date that **Plan Benefits** exceed [$30,000.00]	The range will be 10 - 90 days. The range will be $10,000 - $100,000.
The **Policyholder** or **Third Party Administrator** will also comply with other claim reporting requirements, provided the **Company** sends written notice to the **Policyholder** or **Third Party Administrator** of these requirements and allows the **Policyholder** or **Third Party Administrator** [thirty (30)] days to begin complying with the new requirements.	The range will be 30 - 90 days.
[Failure to furnish written notice will not invalidate or reduce any claim if it was not reasonably possible to provide such written notice within the time period required.]	This will be in or out.

[If the **Company** determines it was reasonably possible to provide written notice in accordance with the provisions of this paragraph, the **Company** may adjust the reimbursement to reflect savings the **Company** may have obtained had the **Company** received notice within [thirty-one (31)] days.]

This will be in or out. If in:

The range will be 10 - 90 days.

In no event will the **Company** be liable for any claims submitted for reimbursement more than [twelve (12)] months after the end of the **Benefit Period**.

The range will be 3 - 24 months.

SECTION VIII – EXCLUSIONS AND LIMITATIONS

18. [Expenses related to drug and alcohol addiction [or mental illness] shall be limited to the lesser of the underlying **Plan** maximum or the Specific **Deductible**].

This will be in or out.

19. [Expenses relating to:
    a. non-human organ/tissue transplants
    b. invitro-fertilization
    c. expenses relating to radial keratotomy
    d. expenses relating to reversal of voluntary sterilization
    e. gene therapy
    f. cloning]

This will be in or out.

20. [Charges billed by a hospital or facility, which are in excess of:

This will be in or out. If in:

    a. [the manufacturer's invoice plus [20]% for medical/surgical supplies and devices billed under the following revenue codes, as published by the National Uniform Billing Committee, including but not limited to:
        1) 274 - Prosthetic/orthotic devices
        2) 275 - Pacemaker
        3) 276 - Intraocular lens
        4) 277 - Other implants
        5) 278 - Other supplies/devices
        6) 279 - Other supplies/devices

        If the manufacturer's invoice is not made available to the **Company**, charges billed under the above revenue codes will be limited to the manufacturer's suggested retail price plus [20]%.]

The range will be 5% - 50%.

The range will be 5% - 50%.

    b. [the average wholesale price (AWP) for prescription drugs billed under the following revenue codes, as published by the National Uniform Billing Committee, including but not limited to:
        1) 250 - General
        2) 251 - Generic drugs
        3) 252 - Nongeneric drugs
        4) 253 - Take-home drugs
        5) 259 - Other pharmacy
        6) 630 - General
        7) 631 - Single source drug
        8) 632 - Multiple source drug
        9) 633 - Restrictive prescription
        10) 634 - Erythropoietin (EPO) less than 10,000 units

This will be in or out. If in:

11) 635 - Erythropoietin (EPO) 10,000 or more units
12) 636 - Drugs requiring detailed coding
13) 637 - Self-Administrable drugs

The average wholesale price allowable will be based on the most current version of [RED BOOK by Thomson Micromedex.]	The average wholesales price will be as published by RED BOOK by Thomson Micromedex, Price Point Rx by First DataBank, Price Rx Select by Medi-Span, or other reputable vendor.
21. [Charges in excess of the **Reasonable and Customary Charge**, whether or not the service or supply was rendered by a provider participating in a **Provider Network(s)**.]	This will be in or out.

SECTION IX – TERMINATION

By the Policyholder

giving the **Company** at least [thirty-one (31)] days	The range will be 31 - 90 days.

By the Company

1. …does not rectify such failures within [ten (10)] days…	The range will be 10 - 30 days.
3. …or insurance plans exceeds [40%] of employees…	The range will be 25% - 60%.
5. …allow the **Policyholder** [ninety (90)] calendar days…	The range will be 30 - 120 days.
6. …giving the **Policyholder** at least [thirty (30)] days…	The range will be 30 - 120 days.

Automatic

5. [sixty (60)] days after the Effective Date if the **Policyholder** has failed to furnish the **Company** with any information or materials requested by the **Company**.	The range will be 30 - 90 days.
If such amounts paid by the **Company** are greater than the amount of the refund due the **Policyholder**, the **Policyholder** shall pay the amount of the deficit to the **Company** within [thirty (30)] days of notice from the **Company**.	The range will be 15 - 60 days.
If repayment in full is not made within this [thirty (30)] day period, the **Company** will be entitled to assess monthly a	The range will be 15 - 60 days.
late payment fee equal to [1.5%] of the outstanding balance.	The range will be 1.5% - 3%.

SECTION X – GENERAL PROVISIONS

Entire Policy

[Renewal]	This will be in or out.

Third Party Administrator

[Renewal]	This will be in or out.
The **Policyholder** must provide written notice to the **Company** at least [sixty (60)] days prior to the effective date of change.	The range will be 30 - 90 days.

Reporting

The **Policyholder** will submit by the [fifteenth (15th)] day of each month…	The range will be 10 - 20 days.

Records
The **Policyholder** will maintain records of all **Covered Persons** under the **Plan** during the **Policy Period** and for a period of [seven (7)] years after termination of the **Policy**. The range will be 1 - 50 years.

Clerical Error
The **Company** will within [fifteen (15)] days of receipt of corrected data decide the corrective course of action under the terms of Misstated Data provision below. The range will be 15 - 60 days.

Misstated Data
1. …the **Policyholder** shall pay the amount of the deficit to the **Company** within [thirty (30)] days of notice from the Company. The range will be 15 - 60 days.

…If repayment in full is not made within this [thirty (30)] day period, The range will be 15 - 60 days.

…the **Company** will be entitled to assess monthly a late payment fee equal to [1.5%] of the outstanding balance; The range will be 1.5% - 3%.

Provider Network(s)
…[The **Policyholder** or **Third Party Administrator** will provide the **Company** with the corresponding **Provider Network(s)** contract(s), upon request.]… This will be in or out.

…submitted to the **Company** at least [sixty (60)] days… The range will be 30 - 90 days.

Suit Against the Company
No suit, action or proceeding against the **Company** for the recovery of any claim will be sustained in any court of law or equity unless: the **Policyholder** has fully complied with all the provisions of this **Policy** and legal action is started within [twelve (12)] months after the end of the **Benefit Period**. The range will be 12 - 24 months.

If under the insurance laws of the applicable jurisdiction such [twelve (12)] months limitation is invalid, then any such legal action needs to be started within the shortest limit of time permitted by such laws. The range will be 12 - 24 months.

ENDORSEMENTS

Policyholder Disclosure Statement
The attached disclosure form must be completed and signed by the appropriate parties no more than [thirty (30)] days prior to the proposed Effective Date of Integrated Stop Loss coverage and received by the Company within [five (5)] days of completion. The range will be 15 - 90 days.

The range will be 5 - 30 days.

Upon receipt of the completed disclosure, the **Company** will assess all data, new and previously reported, and will inform the producer in writing within [five (5)] days of any changes to the rates, factors or terms of coverage. The range will be 5 - 30 days.

List on the Disclosure Form all persons who are known to:
2. Have received medical services during the past twelve months the cost of which exceeds [$15,000] and for which bills have been received by the claims administrator and entered into the claims system. The range will be $5,000 - $50,000.
3. Have been identified as a candidate for case

management and as having the potential to exceed [$15,000] during the policy period. — The range will be $5,000 - $50,000.

4. Have been diagnosed within the past twelve months, with a condition represented by any of the ICD-9 codes contained in the attached list [and have also received medical services costing $5,000 during the same period] — This will be in or out.

Aggregate Terminal Liability

Monthly Terminal Liability Extension Factors:

[$442.78 Single] — Varies by calculation.

[$1,100.94 Family] — Varies by calculation.

TERMINAL LIABILITY EXTENSION PERIOD means [three (3)] consecutive calendar months… — The range will be 1 - 6 consecutive calendar months.

a. multiply the Monthly Terminal Liability Extension Factors (indicated above) by the average number of **Covered Units** for the [three (3)] month period immediately preceding the termination date; — The range will be 1 - 6.

b. multiply by [three (3)]; — The range will be 1 - 6.

the **Company** will extend the Aggregate Stop Loss Coverage for an additional [three (3)] months — The range will be 1 - 6.

c. …the **Policyholder's** obligation is an additional premium of [$1.00]… — The range will be $0.00 - $5.00.

Organ and Tissue Transplant Coverage

[Any charge which is covered in whole or in part under an organ and/or tissue transplant insurance policy is not an **Eligible Claim Expense** under this **Policy**.] — This will be in if the organ and/or tissue transplant insurance policy is NOT issued by a Zurich Company. Otherwise, it will be out.

[Any charge which is covered in whole or in part under the Zurich Company Policy No. xx-xx-xxx is not an **Eligible Claim Expense** under this **Policy**.] — This will be in if the organ and/or tissue transplant insurance policy is issued by a Zurich Company. Otherwise, it will be out.

Blank Endorsement

[This endorsement will be used to make the following changes to the **Policy** which are administrative in nature: — Varies by use.

(1) changes to the SCHEDULE OF INTEGRATED STOP LOSS INSURANCE page; (2) additions or deletions of a subsidiary of the **Policyholder**; (3) modifications which comply with the variable items in the policy filing such as the Claims Basis]

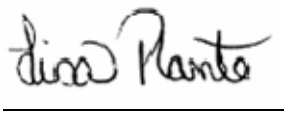
Certificate of Readability

Zurich American Insurance Company

I have reviewed or supervised the preparation of the attached policy forms. I hereby certify that to the best of my knowledge, information, and belief, these policy forms comply with the minimum readability standards required by your State Insurance Code.

The policy forms listed below have achieved the following Flesch Scores using the Flesch Reading Ease software published by Micro Power & Light Co.:

Form Number	Title	Flesch Score
U-ISL-100-A CW (06/08)	ZAIC Integrated Stop Loss Policy	39
U-ISL-101-A CW (06/08)	ZAIC Policyholder Disclosure Statement	41
U-ISL-102-A CW (06/08)	ZAIC Aggregate Terminal Liability Endorsement	40
U-ISL-103-A CW (06/08)	ZAIC Retiree Endorsement	57
U-ISL-104-A CW (06/08)	ZAIC Organ and Tissue Transplant Coverage Endorsement	59
U-ISL-105-A CW (06/08)	ZAIC Blank Endorsement	57
U-ISL-106-A CW (06/08)	ZAIC Privacy Notice	23

Signature: 

Officer: Lisa Plante

Title: Assistant Vice President

Date: July 11, 2008

Zurich American Insurance Company

EXPLANATORY MEMORANDUM

This is a new Integrated Stop Loss Policy form filing responding to the needs of fully-insured groups moving to a self-funded environment. This Policy is intended to provide insurance for self-funded group health plans against catastrophic losses for the self-funded group health plan as a whole.

This Policy will be marketed through brokers, agents, and sales employees. The Company's Integrated Stop Loss Policies will be underwritten by the Company's managing general underwriter, Spectrum Underwriting Managers, Inc.

Any rate manuals and actuarial memoranda filed are trade secrets and should not be disclosed to a third party unless required by law.

Zurich North America

Head Office 1400 American Lane Schaumburg, Illinois
60196-1056

Telephone (847) 605-3763 linda.kulpa@zurichna.com

ZURICH

July 29, 2008

Reference: **Integrated Stop Loss Policy**
Zurich American Insurance Company NAIC# 212 16535
Company Filing # CW-AH-27574

Dear Sir or Madam:

In accordance with the filing requirements of your state, we enclose for your review and approval a new Integrated Stop Loss Policy Program. This Policy is intended to provide insurance for Self-Funded Group Health Plans against catastrophic losses for the self-funded group health plans as a whole. The Program will be marketed through brokers, agents, and sales employees. The Company's Integrated Stop Loss Policies will be underwritten by the company's underwriters as well as managing general underwriter, Spectrum Underwriting Managers, Inc.

A Readability Certification is included with this filing. If you have further readability requirements, please advise us to your specific concerns.

We thereby request an effective date of September 1, 2008, or as soon as statutes permit.

Sincerely,

Linda Kulpa

Linda Kulpa, Filing Analyst